

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DISEASE OR INJURY IS SUSPECTED. IF A MEDICAL EXAMINER IS NOT AVAILABLE, THE REGISTRAR MAY EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 4. SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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30M 7/73

FOR Items 18a. & 22a. DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
1- STATE REGISTRAR										20881	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR		2b. HOUR
Joseph Bemery						5 7 19 80			M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
Male	Black	8 12 1911		69 YRS.	MONTHS DAYS HOURS MIN				5 10 19 80		2:40P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Cambridge			✓						Dorchester County, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			604 Robbins Street			Bur. of Sanation					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
MD			Dorchester		Cambridge		YES <input type="checkbox"/> NO <input type="checkbox"/>		606 Robin St. Dorchest Co.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST			FIRST MIDDLE LAST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
			220-16-7651								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
4409 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION					
						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED					
Thomas D. Smith			M.D. Deputy Chief			5/11/80					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
Thomas D. Smith, M.D.			111 Penn St. Balto., MD.								
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		COUNTY STATE	
Cremation			8/20/80		Westview Crematory			Baltimore		MD	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
C. L. H. Powell F/H			AUG 22 1980			R. J. McCreedy					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 0 8 8 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William Harold Blake			2a. DATE OF DEATH MONTH DAY YEAR Aug 21 1980			2b. HOUR 3:04 PM				
3. SEX male		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR 9 6 19		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.				
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Clothing		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Dorchester		13c. CITY OR TOWN E. New Market		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. Box 132	
14. FATHER'S NAME FIRST MIDDLE LAST William Howard Blake			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Hackett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 215-26-4327		17. INFORMANT P. O. BOX 132 Ann Blake East New Market, MD 21631					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of colon</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with metastases to liver</u> (c) <u>6 mos.</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION 1976			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Above			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 20</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Lewis M. Burkette			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 21 Aug 80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M. Burkette			22e. ADDRESS 4 Aurora St Cambridge MD 21613							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-23-80		23c. NAME OF CEMETERY OR CREMATORY East New Market		23d. LOCATION CITY OR TOWN COUNTY STATE East New Market, Dorch. MD			
24. FUNERAL DIRECTOR NAME Zeller Funeral Home, East New Market, MD			ADDRESS East New Market, MD			25a. DATE REC'D. BY REGISTRAR AUG 20 1980		25b. REGISTRAR'S SIGNATURE		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 20883			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen S. BLIZZARD				2a. DATE OF DEATH MONTH DAY YEAR Aug. 20 1980			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 17 05		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.	
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.				13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE	
14. FATHER'S NAME FIRST MIDDLE LAST (UNKNOWN)				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS same address Lester Blizzard, husband, 21677			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Ant M.I.</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/16</u> , 19 <u>80</u> , to <u>8/20</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8/20</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Umberto</u>				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/20/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) UMBERTO VENTURA				22e. ADDRESS 400 AURORA 85, Cambridge Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/25/80		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR AUG 22 1980		25b. REGISTRAR'S SIGNATURE <u>Rafael</u>	
25c. ADDRESS 3331 Brehms Lane Balto., Md. 21213							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 0 8 8 4			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Howard P. Brannock						2a. DATE OF DEATH MONTH DAY YEAR July 31, '80				2b. HOUR 12:10			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 29, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 59		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? Dor.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.							
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Genl. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic, auto		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Dor. Cambridge										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 305 Nathan Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST John H. Brannock				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Fitzhugh									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 215-14-3091		17. INFORMANT ADDRESS Mrs. Alice Brannock, Cambridge, Md.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left Lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatomas of Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic carcinoma of Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1629										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months 5 months 5 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/2/80</u> , 19 <u>80</u> , to <u>7/31/80</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7/30/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Lawrence Manyakov MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/31/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence Manyakov, MD				22e. ADDRESS 600 Race St Cambridge, Md 21613									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY East New Market Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Dor. Md.					
24. FUNERAL DIRECTOR NAME Thomas Funeral Home, Cambridge, Md.				25a. DATE REC'D. BY REGISTRAR AUG 11 1980				25b. REGISTRAR'S SIGNATURE [Signature]					



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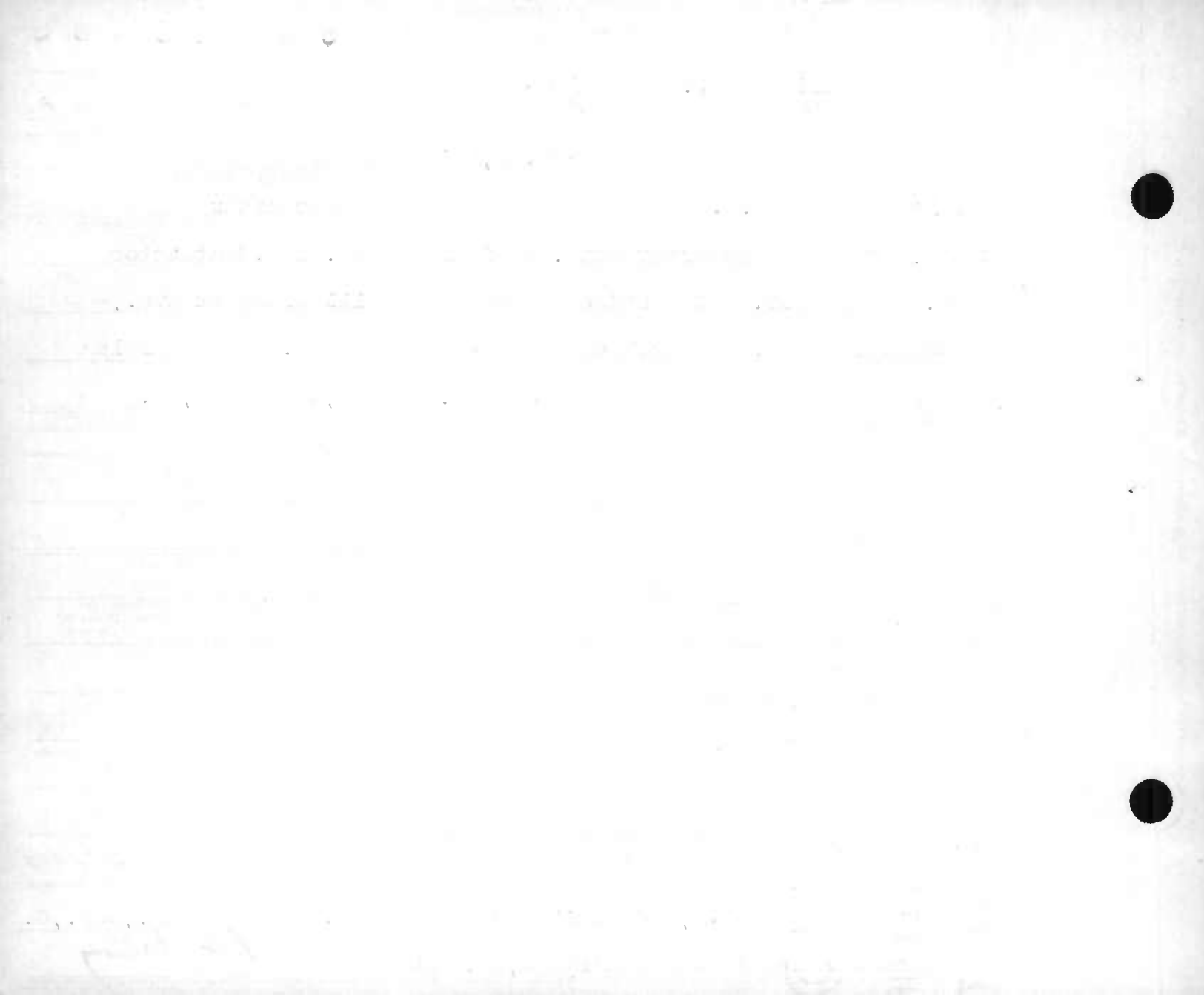
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 0 8 8 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Philip C. Brohawn</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9 30 80</b>		2b. HOUR <b>10.45 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 9, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester Genl. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Bldg. Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles E. Brohawn</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada V. Asplen</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO		17. INFORMANT <b>Jean S. Brohawn, Cambridge, Md.</b>		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca of Lung</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>CVA, Hypertension</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>E. Tanman</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-30-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Tanman</b>		22e. ADDRESS <b>17 Franklin St. Cambridge, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 2, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>East New Mkt., Dor., d.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Thomas Funeral Home, Cambridge, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 3 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	

BP

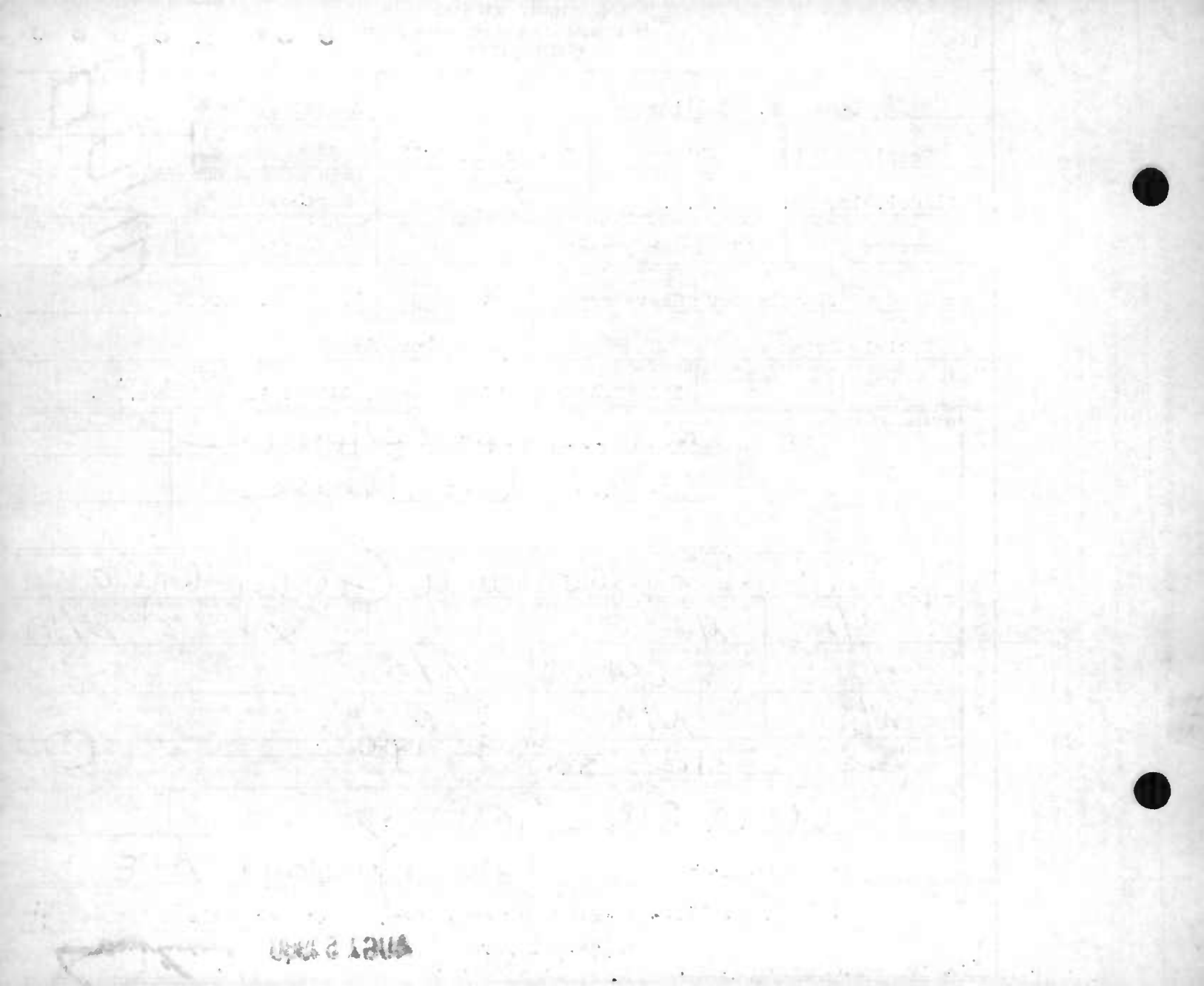


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 80120886					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lena R. Collins					2a. DATE OF DEATH MONTH DAY YEAR August 8, 1980			2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 5, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philadelphia, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.				
10. CITY OR TOWN OF DEATH Secretary		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 130 South Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Secretary		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 130 South Street		
14. FATHER'S NAME FIRST MIDDLE LAST Louigi Memmo					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Verzulli					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-22-4688		17. INFORMANT ADDRESS Darby, Pa. Alfred Memmo, 140 N. Pennock Ave., Upper						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b) <u>Ventricular Septal Defect</u>										
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A						
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19, 1980</u> to <u>July 2, 1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>AR WILKE</u>					DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A R WILKE					22e. ADDRESS 400 Maryland Ave					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 12, 1980		23c. NAME OF CEMETERY OR CREMATORY East New Market Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE East New Market, Maryland			
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home					ADDRESS Federalsburg		25a. SIGNED BY REGISTRAR AUG 15 1980		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 0 8 8 7			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Richard G Collins</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>08 17 80</b>		2b. HOUR <b>11:45 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 04 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <b>130 South Street</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Secretary</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard Collins</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Boyer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO <b>217-05-4972</b>		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>496- Pneumonia</b> IMMEDIATE CAUSE (a) <b>COPD</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John A. Kelly</b> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 22, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>East New Market, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Frampton-Hawkins Funeral Home, 216 N. Main St.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 26 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Richard A. Kelly</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last LILLIE A. EVANS			2a. DATE OF DEATH Month Day Year 8-07-80			2b. HOUR 11:5 A.M.											
3. SEX Female		4. RACE White-Cauc		5. DATE OF BIRTH 11/23/79		6. AGE (In years last birthday) 100 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN							
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.											
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glasgow N. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Worcester			13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 601 Market Street							
14. FATHER'S NAME First Middle Last John Wesley Burton			15. MOTHER'S MAIDEN NAME First Middle Last Malissa Hall			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) No						16b. SOCIAL SECURITY NO. 220-46-6749S		17. INFORMANT Alice E. Walters		809 Market Street Pocomoke City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) GENERALIZED ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SENILE DEMENTIA																	
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Dec 1978, to Aug 7, 1980, that (I) (we) last saw the deceased alive on Aug 7, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Michael A. Moskiewicz														DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8/7/80	
22d. PHYSICIAN'S NAME (Type) MICHAEL A. MOSKIEWICZ														22e. ADDRESS 303 BYRN ST CAMBRIDGE			
23a. BURIAL, CREMATION, DISPOVAL (Specify) Burial			23b. DATE Aug 9, 1980			23c. NAME OF CEMETERY OR CREMATORY Pitts Creek Presbyterian Cem.			23d. LOCATION (City or Town) (County) (State) Pocomoke Worcester Md.								
24. FUNERAL DIRECTOR Scott F. Nelson														25a. REGISTRAR'S NAME AUG 11 1980		25b. REGISTRAR'S SIGNATURE [Signature]	





1. The first item is the cost of the land, which is \$100,000.00.  
2. The second item is the cost of the buildings, which is \$50,000.00.  
3. The third item is the cost of the furniture, which is \$10,000.00.  
4. The fourth item is the cost of the equipment, which is \$5,000.00.  
5. The fifth item is the cost of the inventory, which is \$2,000.00.  
6. The sixth item is the cost of the salaries, which is \$15,000.00.  
7. The seventh item is the cost of the utilities, which is \$1,000.00.  
8. The eighth item is the cost of the insurance, which is \$500.00.  
9. The ninth item is the cost of the taxes, which is \$1,000.00.  
10. The tenth item is the cost of the interest, which is \$1,000.00.

11. The eleventh item is the cost of the depreciation, which is \$1,000.00.  
12. The twelfth item is the cost of the maintenance, which is \$1,000.00.  
13. The thirteenth item is the cost of the repairs, which is \$1,000.00.  
14. The fourteenth item is the cost of the advertising, which is \$1,000.00.  
15. The fifteenth item is the cost of the transportation, which is \$1,000.00.  
16. The sixteenth item is the cost of the communication, which is \$1,000.00.  
17. The seventeenth item is the cost of the entertainment, which is \$1,000.00.  
18. The eighteenth item is the cost of the education, which is \$1,000.00.  
19. The nineteenth item is the cost of the health, which is \$1,000.00.  
20. The twentieth item is the cost of the recreation, which is \$1,000.00.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 0 8 8 9  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

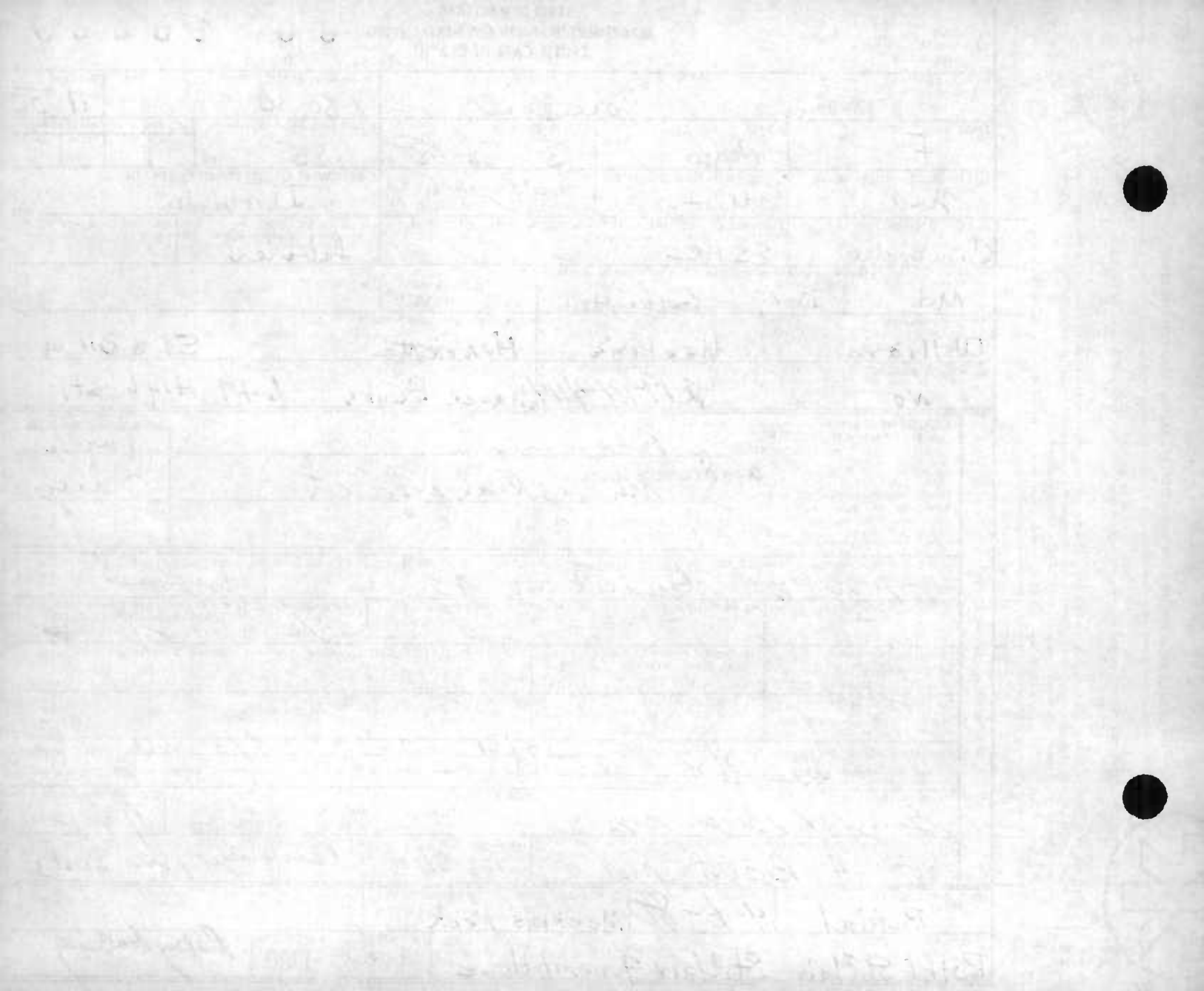
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Mary Meekins</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8-30-80</i>			2b. HOUR <i>11 P.M.</i>	
3 SEX <i>F</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 12 95</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 YRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD.		
10 CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ESHC</i>			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md</i> 13b. COUNTY <i>Dor.</i> 13c. CITY OR TOWN <i>Golden Hill</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
14 FATHER'S NAME FIRST MIDDLE LAST <i>William Meekins</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Henrietta Slacum</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>219-14-4114</i>		17. INFORMANT <i>Maude Banks</i>		ADDRESS <i>647 High st.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> OR AS A CONSEQUENCE OF (b) <i>Myocardial infarct</i> DUE TO, OR AS A CONSEQUENCE OF (c) 486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>3 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>HASCUVD Generalized AS</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/28</i> 19 <i>76</i> , to <i>8/30</i> 19 <i>80</i> , that (I) (we) last saw the deceased <i>above</i> <i>8/30</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.							
22b. SIGNATURE <i>George W. Beck MD</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/30/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>6030 H BECK MD</i>				22e. ADDRESS <i>12. St. Clair Cambridge, Md 21613</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>9-6-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meekins Neck</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Ruth St. Clair St. Clair Funeral Home</i>				25a. DATE REC'D. BY REGISTRAR <i>SEP 2 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony Kennedy</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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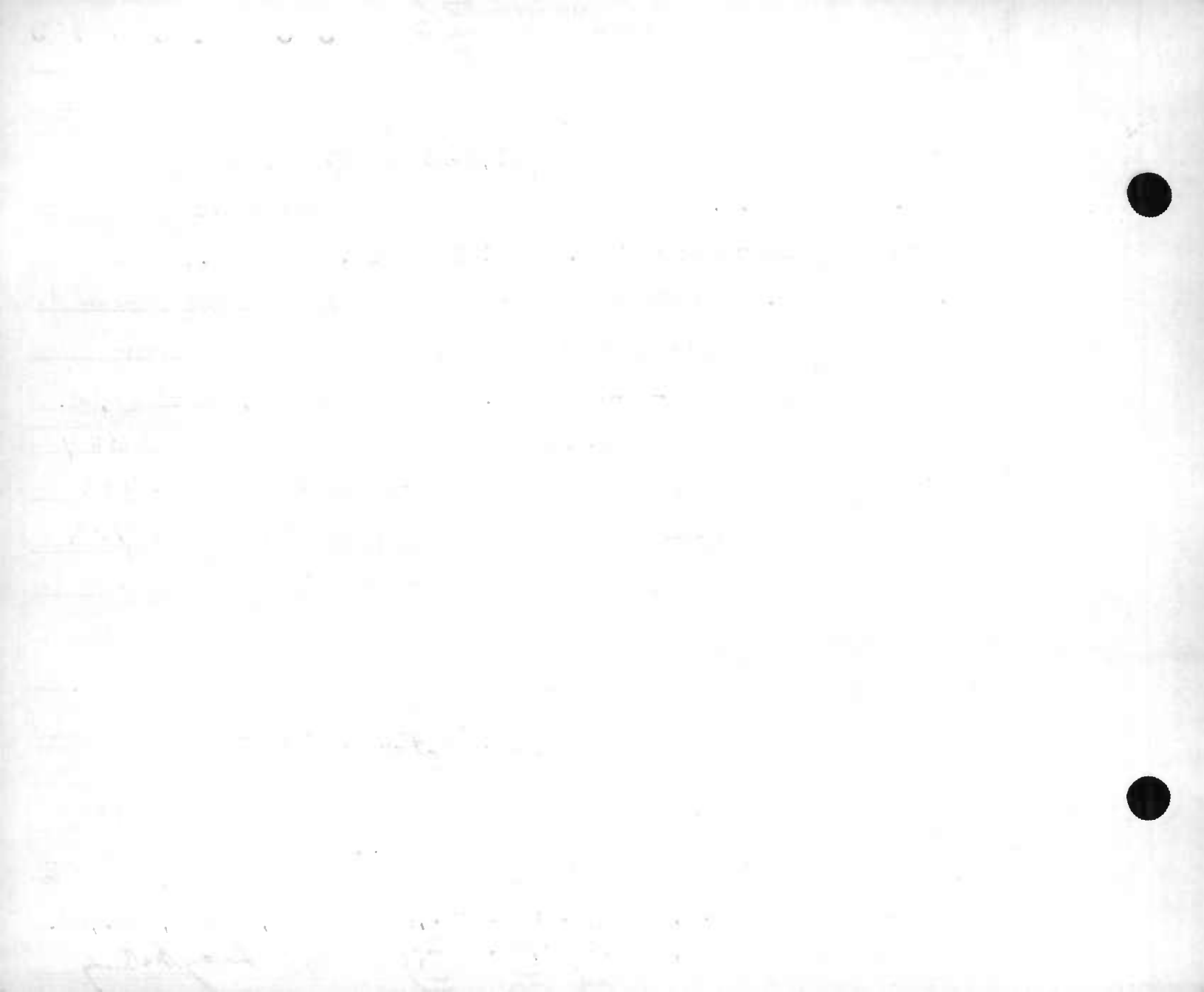


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8020890											
1. FOR STATE REGISTRAR		REG. NO.																			
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH		DAY		YEAR		2b HOUR					
Samuel Y Monaghan								8-30-1980		5A						M					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a CITIZENSHIP		7b IF UNDER 1 YEAR		7c IF UNDER 24 HRS		7d MONTHS		7e DAYS		7f HOURS		7g MIN.	
Male		White		May 13, 1913		67 YRS		U.S.													
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZENSHIP OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH															
Penna.		U.S.				Dorchester															
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY															
Cambridge		Dorchester Genl. Hospital		Ret. Sears Mgr.																	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS											
Md.		Dor.		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1405 School street													
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME																			
John		Agne																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS															
YES		WW 2		175-07-2818		Mrs. Rosella Monaghan, Cambridge Md.															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u>										1 day											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Heart Failure</u>										2 yrs											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis of Liver</u>										2 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>nutritional cerebellar degeneration</u>																					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a I certify that (I) (this hospital) attended the deceased from <u>8/22/80</u> to <u>8/30/80</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>8/30/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>see the body after death.</u>																					
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED															
Lawrence Maryanov, MD		MD				8/30/80															
22c PHYSICIAN'S NAME (TYPE OR PRINT)		22d ADDRESS																			
Lawrence Maryanov, MD		610 Kace St Cambridge, Md 21613																			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY		STATE											
Burial		Sept. 2, 1980		Md. Vets. Cem., East Shore		Buelah Dor., Md.															
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE																	
Thomas Funeral Home, Cambridge, Md.		SEP 3 1980		[Signature]																	

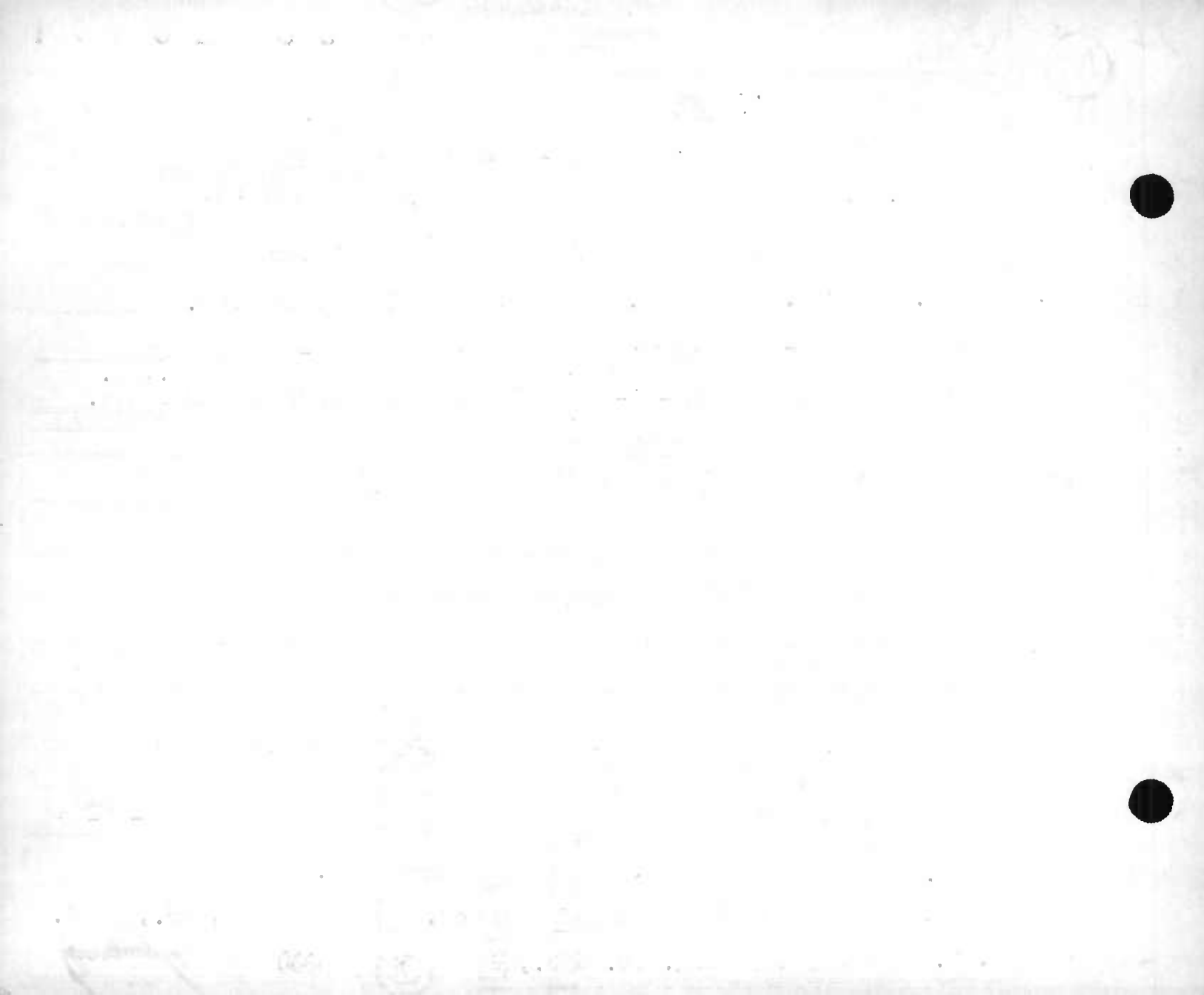


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
REG. NO. 80 20891									
1 DECEASED NAME (TYPE OR PRINT) John Morgan			2a DATE OF DEATH MONTH DAY YEAR 8 27 80			2b HOUR 4:10 M			
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR 3 - 17 - 1918		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10 CITY OR TOWN OF DEATH Cambridge		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Md.		13b COUNTY Dor.		13c CITY OR TOWN Camb.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 706 Moores Ave.	
14 FATHER'S NAME FIRST MIDDLE LAST Ozie - Morgan					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena - Mc Neal				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW 2		17 INFORMANT (Sister) Victoria Spruells		ADDRESS Camb., Md. 706 Moores Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4291 DUE TO, OR AS A CONSEQUENCE OF (b) Degenerative Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary Embolus									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (I) (this hospital) attended the deceased from 8-21-80 to 8-27-80, that (I) (we) last saw the deceased alive on 8-27-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.									
22b SIGNATURE J. Edwin Tassett						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 8-29-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. Edwin Tassett				22e ADDRESS 806 Fairmont Ave.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8-31-80		23c NAME OF CEMETERY OR CREMATORY Bethel AME Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dor., Md.			
24 FUNERAL DIRECTOR NAME L. H. Boardley 603 Wash. St. Camb., Md						25a DATE REC'D. BY REGISTRAR SEP 2 1980		25b REGISTRAR'S SIGNATURE L. H. Boardley	



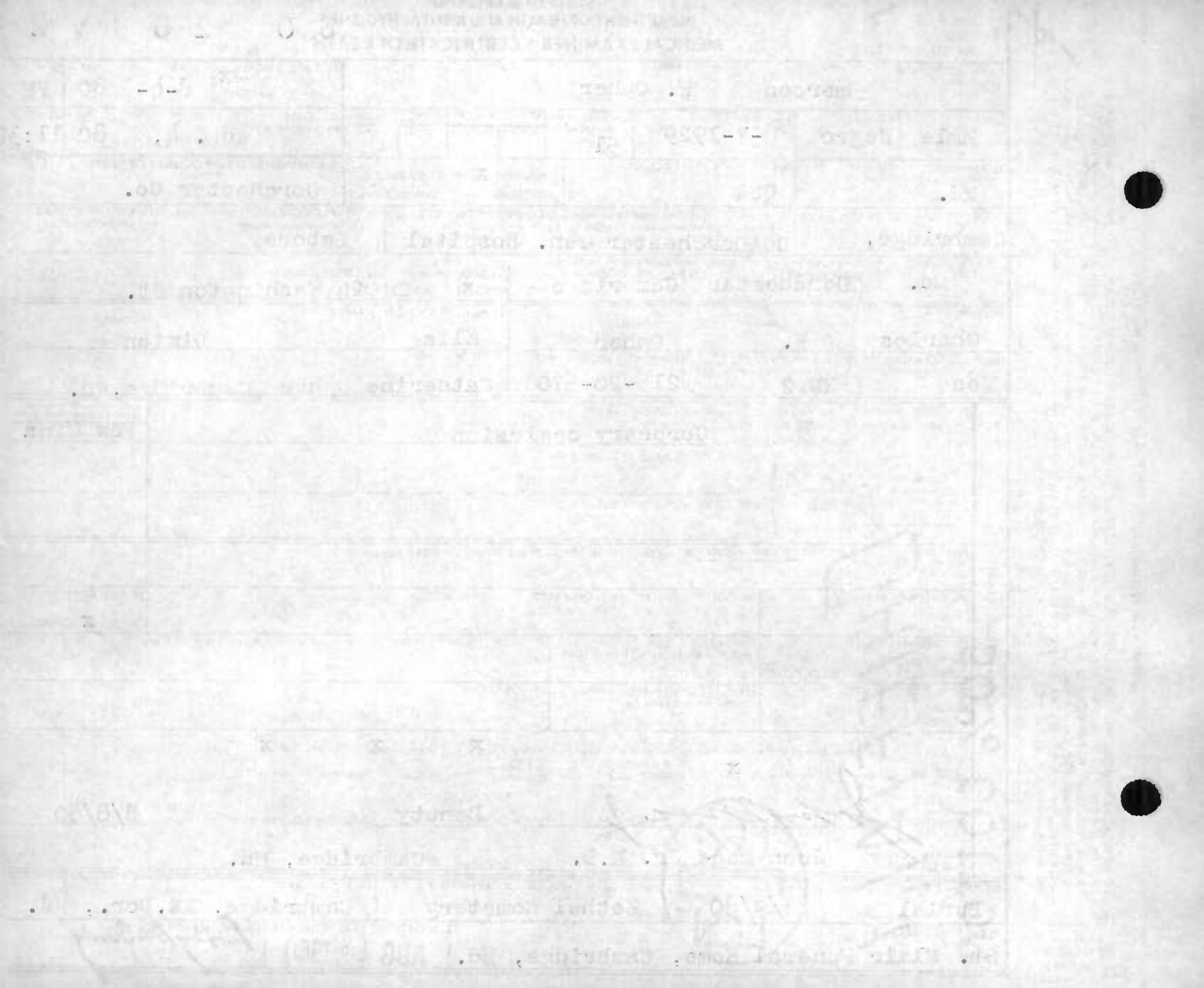


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(V R A 15 ME (S))  
15M/7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0 2 0 8 9 2									
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE KNOWN OF DEATH					MONTH DAY YEAR					2b. HOUR									
Emerson					W. Opher					8-4-					1980					PM									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD					2d. HOUR												
Male		Negro		6-7-1929		51 YRS.						Aug. 4, 1980					11:30 PM												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH														
Md.					USA										Dorchester Co.					MD									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY														
Cambridge,					DOA Dorchester Gen. Hospital					Laborer																			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS									
13a. STATE										13b. COUNTY										13c. CITY OR TOWN									
Md.										Dorchester										Cambridge									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																			
FIRST MIDDLE LAST										FIRST MIDDLE LAST																			
Charles W. Opher										Ella Dixon																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS														
Yes					WW 2					215-26-5708					Catherine Opher					Cambridge, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?														
															YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
					P.M. 19																								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE <i>John Mace Jr.</i>										TITLE (SPECIFY) Deputy										DATE SIGNED 8/8/80									
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																			
John Mace Jr. M.D.										Cambridge, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE														
Burial					8/9/80					Bethel Cemetery					Cambridge, MD. Dor., Md.														
24. FUNERAL DIRECTOR NAME ADDRESS										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
St. Clair Funeral Home, Cambridge, Md.										AUG 12 1980										<i>Robert M. Brady</i>									



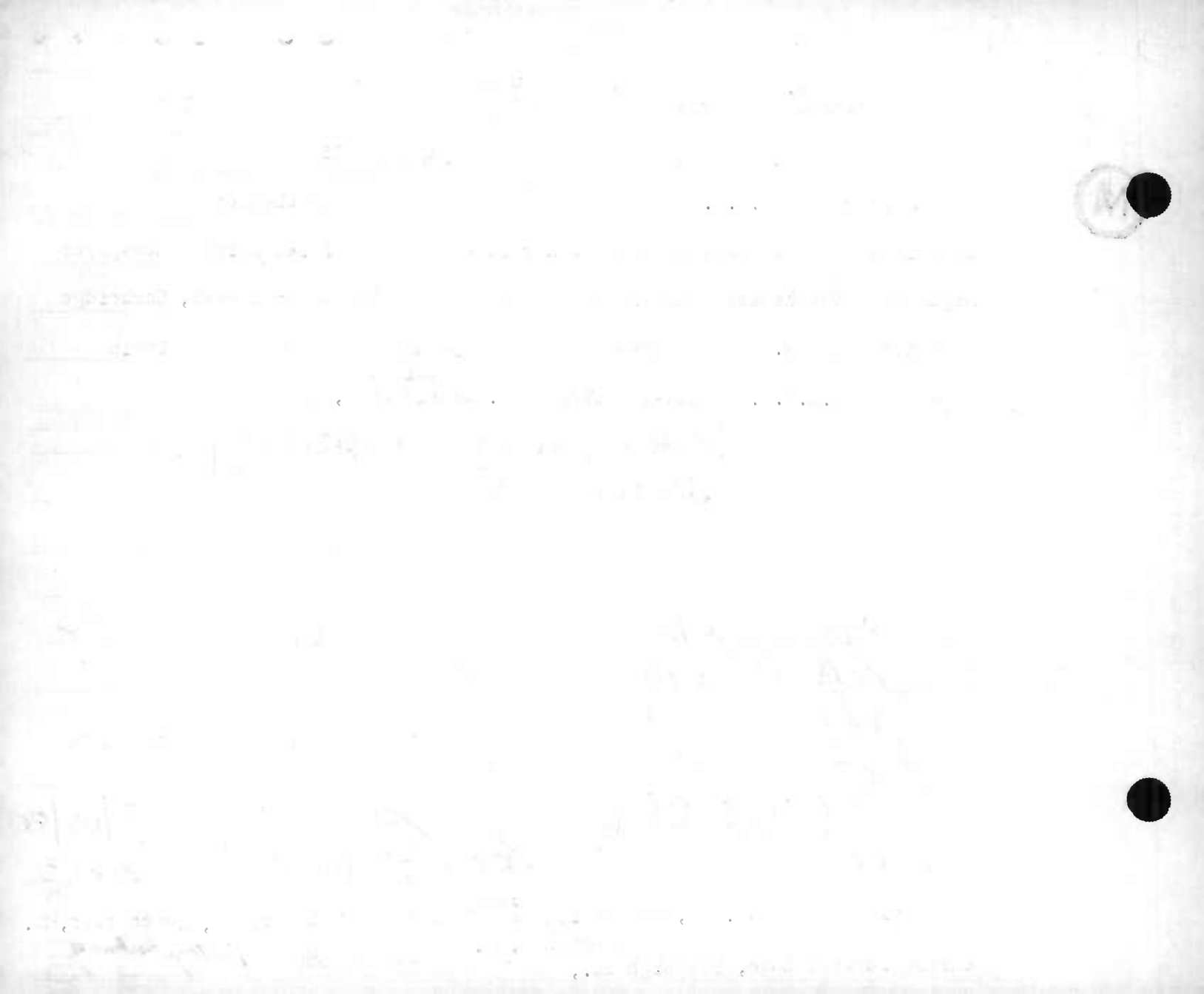
3

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 0 8 9 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>W.</u> MIDDLE <u>Earle</u> LAST <u>Orem</u> <del>XXXXXXXXXXXX</del> <u>OREM</u>				2a. DATE OF DEATH MONTH <u>8</u> DAY <u>15</u> YEAR <u>80</u>		2b. HOUR <u>M</u>	
3. SEX <u>male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH <u>8</u> DAY <u>29</u> YEAR <u>04</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester</u> MD.	
10. CITY OR TOWN OF DEATH <u>Cambridge</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>administrative</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>newspaper</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Dorchester</u>		13c. CITY OR TOWN <u>Cambridge</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <u>Earle</u> MIDDLE <u>W.</u> LAST <u>Orem</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Birdsal</u> MIDDLE <u></u> LAST <u>Drain</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>yes</u>		16b. SOCIAL SECURITY NO. <u>U.S.C.G.</u>		17. INFORMANT (wife) ADDRESS <u>Mrs. Bessie Orem, same as 13E</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic respiratory insufficiency</u> <u>496-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE COPD.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <u>N/A</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>N/A</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N/A</u>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/> <u>N/A</u>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N/A</u>			
22. I certify that (1) (the hospital) attended the deceased from <u>8/15</u> 19 <u>80</u> to <u>8/15</u> 19 <u>80</u> , that (1) (we) lost <u>8/15</u> 19 <u>80</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.							
22a. SIGNATURE <u>Wink</u>		22b. DEGREE <u>Attending Physician</u>				22c. DATE SIGNED <u>8/15/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wink</u>		22e. ADDRESS <u>400 Maryland Ave 21613</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>Aug. 17, 1980</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Episcopal</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Cambridge, Dorchester, Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Curran Funeral Home, 308 High St.,</u>		ADDRESS <u>Cambridge, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 20 1980</u>		25b. REGISTRAR'S SIGNATURE <u>Fitzgerald</u>	

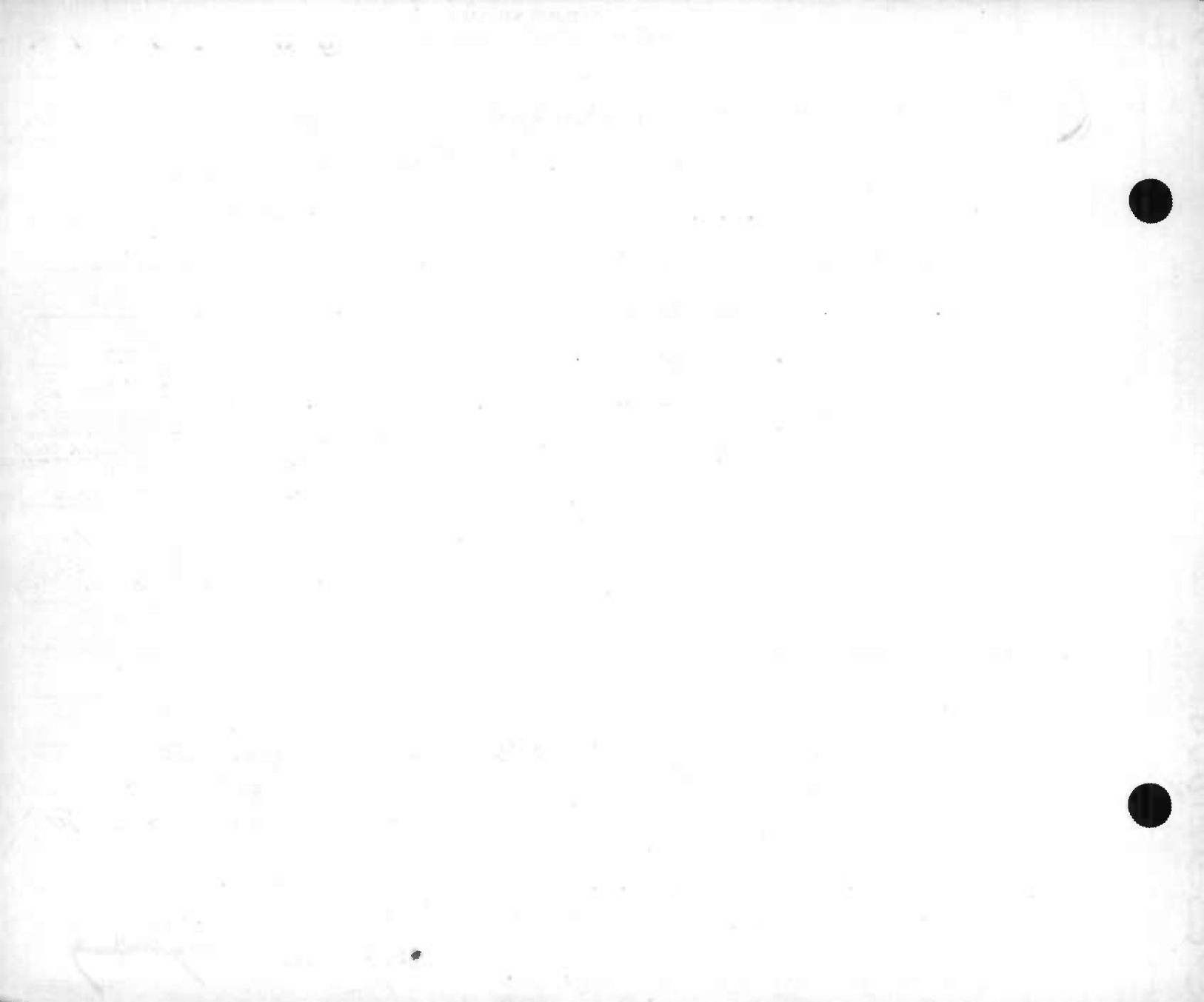


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 20894	
1- FOR STATE REGISTRAR										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Edward B. Parkerson					2a DATE OF DEATH August 31 80			2b HOUR 6:00a M			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH Jan. 11 1906		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter		12b KIND OF BUSINESS OR INDUSTRY Marine		
10 CITY OR TOWN OF DEATH Cambridge					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital					13a STATE Md.	
13b COUNTY Dorchester					13c CITY OR TOWN Hurlock		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rt. 2 Box 165		
14 FATHER'S NAME Ulie V. Parkerson					15 MOTHER'S MAIDEN NAME Rosemary Dunn					16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b SOCIAL SECURITY NO. 257-09-3711					17 INFORMANT Mrs. Margaret G. Parkerson					ADDRESS see item #13	
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL MYOCARDIAL INFARCTION OR</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10+ YRS</u> <u>10+ YRS.</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE &amp; PULM. EMPHYSEMA, SEVERE &amp; RESPIR. FAILURE</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>5/16</u> 19 <u>66</u> to <u>8/31</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>8/31</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Donald R. McWilliams</u>					DEGREE M.D.					22c DATE SIGNED 8-31-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Donald R. McWilliams, M.D.					22e ADDRESS East New Market, Md.						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 9-3-80		23c NAME OF CEMETERY OR CREMATORY Oxford Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Oxford Talbot Md		25a DATE REC'D. BY REGISTRAR SEP 8 1980		
24 FUNERAL DIRECTOR NAME Newnam Funeral Home					ADDRESS Easton, Md.			25b REGISTRAR'S SIGNATURE <u>Harry M. [Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 2 0 8 9 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>HARVEY LINDEN RANDALL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>AUG 1, 1980</b>		2b. HOUR <b>4:10 P M</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 01 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester Co. MD.</b>	
10. CITY OR TOWN OF DEATH <b>3 Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>E5 HC</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Armour + Co.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE <b>md.</b>		13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>Cambridge</b>		13e. STREET ADDRESS <b>Box 1918 Rt. 4 Cambridge, md</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LOUIS RANDALL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lottie Finchon</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-05-1729</b>		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary failure</b> <b>4409</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>Bilateral pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO OR AS A CONSEQUENCE OF (c) <b>General arteriosclerosis</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>3 days</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>Jan 24, 19 79</b> to <b>Aug 1, 19 80</b> , that (I) <b>last</b> saw the deceased alive on <b>1 Aug 19 80</b> and that in (my) <b>last</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>did not</b> view the body after death.							
22b. SIGNATURE <b>Paul A. Stagg, MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1 Aug 80</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL A. STAGG</b>				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>8/4/80</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Anatomy Board of Md. 655 W. Baltost</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 8 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Henry M. Brady</b>	



Aug 1, 1950 4:15

HARVEY LINEN RANDBAL

Note: Concession

3 hours  
3 days  
Yacht

Cardinal's failure  
to obtain the  
General's assistance

Levee

Aug 1, 1950

X 1950

PAUL A. STARK  
Paul A. Stark, Jr.  
Aug 24, 1950

TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 0 8 9 6			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MILTON ALBERT RUARK</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 7, 1980</b>		2b. HOUR <b>2:08 P M</b>	
3 SEX <b>M</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 1, 1916</b>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>64 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Salisbury, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Eastern Shore State Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Boilermaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bread Co.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Mina A. Ruark</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Emily Adkins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>222-07-4845A</b>		17. INFORMANT ADDRESS <b>Mrs. Virginia E. Ruark (wife) same as 13</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONITIS</b> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>MANY YEARS</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>NONE</b>							
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>- - - 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>-</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>- - - - -</b>			
22a. I certify that (this hospital) attended the deceased from <b>OCT 27 19 79</b> to <b>AUG 7 19 80</b> , that (we) lost saw the deceased alive on <b>AUG 7 19 80</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did) view the body after death.							
22b. SIGNATURE <b>Paul A. Staggs, MD.</b>				DEGREE <b>MD.</b>		22c. DATE SIGNED <b>7 AUG 80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul A. Staggs, MD.</b>				22e. ADDRESS <b>Cambridge, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/9/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pittsville Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pittsville, Wic., Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>HOLLOWAY FUNERAL HOME, Salisbury, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>	

August 7, 1980

MILTON ALBERT QUAY

White

11

10 DAYS  
MAY YEARS

PNEUMONITIS  
ARTEROSCLEROSIS

None

Aug 7 80  
Aug 7 80

Aug 80 x

Don't stop, Mr.

Aug 11 1980

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 20897

1. FOR STATE REGISTRAR		2b. DATE KNOWN OF DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR 1:00 a.m.	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE KNOWN OF DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR 1:00 a.m.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH Oct. 5, 1957		6. AGE (IN YEARS) 21 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS		21a. INJURY OCCURRED		21b. PLACE OF INJURY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION	
PART 1 DEATH WAS CAUSED BY:				21e. PLACE OF INJURY		21f. LOCATION	
IMMEDIATE CAUSE (a) Gunshot wound of chest (.22 cal. rifle)				21g. TIME OF INJURY		21h. LOCATION	
DUE TO, OR AS A CONSEQUENCE OF				21i. PLACE OF INJURY		21j. LOCATION	
DUE TO, OR AS A CONSEQUENCE OF				21k. TIME OF INJURY		21l. LOCATION	
DUE TO, OR AS A CONSEQUENCE OF				21m. TIME OF INJURY		21n. LOCATION	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				21o. TIME OF INJURY		21p. LOCATION	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION	
UNDERLYING <input checked="" type="checkbox"/> OR		21e. PLACE OF INJURY		21f. LOCATION		21g. LOCATION	
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21h. TIME OF INJURY		21i. PLACE OF INJURY		21j. LOCATION	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>		21h. TIME OF INJURY		21i. PLACE OF INJURY		21j. LOCATION	
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21k. TIME OF INJURY		21l. LOCATION		21m. LOCATION	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		21n. LOCATION		21o. LOCATION	
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		21p. LOCATION		21q. LOCATION	
ACTUAL SIGNATURE		MEDICAL EXAMINER		DATE SIGNED		8/11/80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Thomas D. Smith, M.D.		111 Penn St. Balto., MD.		Burial		Aug. 14, 1980	
24. FUNERAL DIRECTOR NAME		ADDRESS		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Frampton-Hawkins		Federalburg, Md.		Washington Cemetery		Hurlock, Dorchester, Maryland	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. NAME OF CEMETERY OR CREMATORY		25d. LOCATION	
AUG 19 1980		[Signature]		Washington Cemetery		Hurlock, Dorchester, Maryland	

1990 2 0 6

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 0 8 9 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Virgil</i>	MIDDLE <i>Brooks</i>	LAST <i>Turner</i>	2a. DATE OF DEATH		MONTH <i>8</i>	DAY <i>4</i>	YEAR <i>80</i>	2b. HOUR <i>12 N</i>	
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>08 - 19 - 15</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i>		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cambridge House</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>None</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Dorchester</i>		13c. CITY OR TOWN <i>Cambridge</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>520 Glenburn Avenue</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Clellie Turner</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nellie (unknown)</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		(IF YES, GIVE WAR OR DATES) <i>-</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT P. ADDRESS <i>Dorothy Startt Easton, MD 21601</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Septicemia</i> <i>5990</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Septic shock</i> (c) <i>Urinary T. Infection</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Poor General Condition, Parkinson's Disease, Ovarian B. Syndrome</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>E. Tanman</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. Tanman</i>				22e. ADDRESS <i>17 Franklin St. Cambridge, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-7-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>East New Market</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>East New Market, Dor. MD</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>Zeller Funeral Home, East New Market, MD</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 18 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Harry M. Brady</i>					

35  
70  
35  
191  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon duplicate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



EXHIBIT

IN RE

THE

UNITED STATES OF AMERICA

VS

JOHN

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EXHIBIT 8

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 20899	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST CLARA H WALKER			2a. DATE OF DEATH MONTH DAY YEAR 8 25 80			2b. HOUR M		
3. SEX FEMALE		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR July 5, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester 1105 Holland Ave. MD.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Genl. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE Md.			13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Richard Meekins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Ann Maguire			13e. STREET ADDRESS 1105 Holland Ave.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-7354			17. INFORMANT ADDRESS Alva W. Rue, Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 436- DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CARCINOMA OF COLON											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C.T. MORROW MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/25/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.T. MORROW						22e. ADDRESS F.R. - DORCHSTR GEN'L HOSP.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 27, 1980		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park, Cambridge, Dor. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		
24. FUNERAL DIRECTOR NAME Thomas Funeral Home, Cambridge, Md.						25a. DATE REC'D. BY REGISTRAR AUG 27 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8020900	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) William Hurst Willoughby										20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 8/9/80 <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 14 16		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		21. DATE PRONOUNCED DEAD Aug. 12 1980		2d HOUR 6:30 PM	
10. CITY OR TOWN OF DEATH Secretary				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sunnyside Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. CITY OR TOWN Dorchester		13c. CITY OR TOWN Secretary		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Sunnyside Road	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Willoughby						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amata Hurst					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 220-01-9550		17. INFORMANT P. O. Box 263 Walter Hurst, Beacon, NY 12508			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Mace Jr. M.D.				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 8/14/80			
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.				ADDRESS Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8-14-80		23c. NAME OF CEMETERY OR CREMATORY East New Market		23d. LOCATION CITY OR TOWN COUNTY STATE EastNewMarket, Dor. Md			
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market MD				ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 20 1980		25b. REGISTRAR'S SIGNATURE Patrick McCready			

